

CAP-MR/DD
Letter of Attestation II
(Used by Existing Providers of any CAP-MR/DD Service, *EXCEPT Residential Supports, Home and Community Supports and Personal Care Services*)

The CAP-MR/DD service definition titled Home Supports is a service that will be delivered by parents, family members and/or guardians who live in the same home as the participant. It is a service that combines the habilitation (skill building and maintenance) service and personal care service. In an effort to support parents/families currently providing services and employed by providers who deliver a range of CAP-MR/DD services, **existing providers** of any CAP-MR/DD service; ***EXCEPT FOR, Residential Supports, Home and Community Supports, Personal Care services***; who intend to provide Home Supports are not required to receive endorsement. **In order to be eligible to provide Home Supports, existing providers** of any CAP-MR/DD service; ***EXCEPT FOR, Residential Supports, Home and Community Supports, Personal Care services***, are required to sign this attestation letter demonstrating compliance to the Home Supports service definition requirements.

As a current CAP-MR/DD Medicaid enrolled provider of any CAP-MR/DD service; ***EXCEPT FOR, Residential Supports, Home and Community Supports, Personal Care services***; and in order to be eligible to provide the new CAP-MR/DD waiver service titled Home Supports, I attest to the following:

I fully understand all the requirements of the Home Supports service definition, including, but not limited to, all elements of the definition, limitations, staff training and qualifications. Further, I understand I am solely responsible for ensuring the service is provided as defined in the service definition and am attesting to my compliance to the Home Supports service definition requirements effective November 1, 2008. I understand that the Local Management Entity will monitor my compliance to the Home Supports definition within ***30 days of delivery of the service***. I understand failure to comply with all requirements shall result in withdrawal of provider endorsement and enrollment with DMA.

Provider Signature: _____ (Print Name) _____
Date: _____
Provider Agency: _____
Provider Address: _____
Provider Phone Number: _____
Provider Email Address: _____
Provider Medicaid Enrollment Number _____

- The provider sends this signed ***CAP-MR/DD Letter of Attestation II***, and the completed DMA Addendum Application to DMA, Provider Services.
- The provider sends the original signed ***CAP-MR/DD Letter of Attestation II*** to the LME located in the catchment area where the provider's corporate office is located, and a copy to all LMEs with whom there is a signed MOA.

CC: *LME located in the catchment area where the provider's corporate office is located (original)*
LMEs with whom there is a signed MOA